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- (1) Is usable as a second means of escape by the client(s) occupying the room; and
- (2) Is no more than 44 inches (measured to the window sill) above the floor unless the facility is surveyed under the Health Care Occupancy Chapter of the Life Safety Code, in which case the window must be no more than 36 inches (measured to the window sill) above the floor.
- (3) The survey agency may grant a variance from the limit of four clients per room only if a physician who is a member of the interdisciplinary team and who is a qualified mental retardation professional—
  - (i) Certifies that each client to be placed in a bedroom housing more than four persons is so severely medically impaired as to require direct and continuous monitoring during sleeping hours; and
  - (ii) Documents the reasons why housing in a room of only four or fewer persons would not be medically feasible.
- (4) The facility must provide each client with—
  - (i) A separate bed of proper size and height for the convenience of the client;
  - (ii) A clean, comfortable mattress;
  - (iii) Bedding appropriate to the weather and climate; and
  - (iv) Functional furniture appropriate to the client's needs, and individual closet space in the client's bedroom with clothes racks and shelves accessible to the client.
- (c) *Standard: Storage space in bedroom.* The facility must provide—
  - (1) Space and equipment for daily out-of-bed activity for all clients who are not yet mobile, except those who have a short-term illness or those few clients for whom out-of-bed activity is a threat to health and safety; and
  - (2) Suitable storage space, accessible to clients, for personal possessions, such as TVs, radios, prosthetic equipment and clothing.
- (d) *Standard: Client bathrooms.* The facility must—
  - (1) Provide toilet and bathing facilities appropriate in number, size, and design to meet the needs of the clients;
  - (2) Provide for individual privacy in toilets, bathtubs, and showers; and
  - (3) In areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110° Fahrenheit.
- (e) *Standard: Heating and ventilation.* (1) Each client bedroom in the facility must have—
  - (i) At least one window to the outside; and
  - (ii) Direct outside ventilation by means of windows, air conditioning, or mechanical ventilation.
- (2) The facility must—
  - (i) Maintain the temperature and humidity within a normal comfort range by heating, air conditioning or other means; and
  - (ii) Ensure that the heating apparatus does not constitute a burn or smoke hazard to clients.
- (f) *Standard: Floors.* The facility must have—
  - (1) Floors that have a resilient, non-abrasive, and slip-resistant surface;
  - (2) Nonabrasive carpeting, if the area used by clients is carpeted and serves clients who lie on the floor or ambulate with parts of their bodies, other than feet, touching the floor; and
  - (3) Exposed floor surfaces and floor coverings that promote mobility in areas used by clients, and promote maintenance of sanitary conditions.
- (g) *Standard: Space and equipment.* The facility must—
  - (1) Provide sufficient space and equipment in dining, living, health services, recreation, and program areas (including adequately equipped and sound treated areas for hearing and other evaluations if they are conducted in the facility) to enable staff to provide clients with needed services as required by this subpart and as identified in each client's individual program plan.
  - (2) Furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.

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(3) Provide adequate clean linen and dirty linen storage areas.

(h) *Standard: Emergency plan and procedures.* (1) The facility must develop and implement detailed written plans and procedures to meet all potential emergencies and disasters such as fire, severe weather, and missing clients.

(2) The facility must communicate, periodically review, make the plan available, and provide training to the staff.

(i) *Standard: Evacuation drills.* (1) The facility must hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to—

(i) Ensure that all personnel on all shifts are trained to perform assigned tasks;

(ii) Ensure that all personnel on all shifts are familiar with the use of the facility's fire protection features; and

(iii) Evaluate the effectiveness of emergency and disaster plans and procedures.

(2) The facility must—

(i) Actually evacuate clients during at least one drill each year on each shift;

(ii) Make special provisions for the evacuation of clients with physical disabilities;

(iii) File a report and evaluation on each evacuation drill;

(iv) Investigate all problems with evacuation drills, including accidents, and take corrective action; and

(v) During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.

(3) Facilities must meet the requirements of paragraphs (IX1) and (2) of this section for any live-in and relief staff they utilize.

(j) *Standard: Fire protection—(1) General.* (i) Except as specified in paragraph (jX2) of this section, the facility must meet the applicable provisions of either the Health Care Occupancies Chapters or the Residential Board and Care Occupancies Chapter of the Life Safety Code (LSC) of the National Fire Protection Association,

1985 edition, which is incorporated by reference.<sup>a</sup>

(ii) The State survey agency may apply a single chapter of the LSC to the entire facility or may apply different chapters to different buildings or parts of buildings as permitted by the LSC.

(iii) A facility that meets the LSC definition of a residential board and care occupancy and that has 16 or fewer beds, must have its evacuation capability evaluated in accordance with the Evacuation Difficulty Index of the LSC (Appendix F).

(2) *Exceptions.* (i) For facilities that meet the LSC definition of a health care occupancy:

(A) The State survey agency may waive, for a period it considers appropriate, specific provisions of the LSC if—

(1) The waiver would not adversely affect the health and safety of the clients; and

(2) Rigid application of specific provisions would result in an unreasonable hardship for the facility.

(B) The State survey agency may apply the State's fire and safety code instead of the LSC if the Secretary finds that the State has a code imposed by State law that adequately protects a facility's clients.

(C) Compliance on November 26, 1982 with the 1967 edition of the LSC or compliance on April 18, 1986 with the 1981 edition of the LSC, with or without waivers, is considered to be compliance with this standard as long as the facility continues to remain in

<sup>a</sup> Incorporation of the 1985 edition of the National Fire Protection Association's Life Safety Code (published February 1, 1985; ANSI/NFPA 101) was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR Part 81 that governs the use of incorporations by reference. The Code is available for inspection at the Office of the Federal Register Information Center, Room 8401, 1100 L Street NW., Washington, DC. Copies may be obtained from the National Fire Protection Association, Batterymarch Park, Quincy, Mass. 02269.

If any changes in this Code are also to be incorporated by reference, a notice to that effect will be published in the Federal Register.

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compliance with that edition of the Code.

(U) For facilities that meet the LSC definition of a residential board and care occupancy and that have more than 16 beds, the State survey agency may apply the State's fire and safety code as specified in paragraph (j)(2)(B) of this section.

(k) **Standard: Paint.** The facility must—

(1) Use lead-free paint inside the facility; and

(2) Remove or cover interior paint or plaster containing lead so that it is not accessible to clients.

(l) **Standard: Infection control.**

(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. There must be an active program for the prevention, control, and investigation of infection and communicable diseases.

(2) The facility must implement successful corrective action in affected problem areas.

(3) The facility must maintain a record of incidents and corrective actions related to infections.

(4) The facility must prohibit employees with symptoms or signs of a communicable disease from direct contact with clients and their food.

§ 483.480 Condition of participation: Dietetic services.

(a) **Standard: Food and nutrition services.** (1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.

(2) A qualified dietitian must be employed either full-time, part-time, or on a consultant basis at the facility's discretion.

(3) If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food services.

(4) The client's interdisciplinary team, including a qualified dietitian and physician, must prescribe all modified and special diets including those used as a part of a program to manage inappropriate client behavior.

(5) Foods proposed for use as a primary reinforcement of adaptive behavior are evaluated in light of the client's nutritional status and needs.

(6) Unless otherwise specified by medical needs, the diet must be prepared at least in accordance with the latest edition of the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences, adjusted for age, sex, disability and activity.

(b) **Standard: Meal services.** (1) Each client must receive at least three meals daily, at regular times comparable to normal mealtimes in the community with—

(i) Not more than 14 hours between a substantial evening meal and breakfast of the following day, except on weekends and holidays when a nourishing snack is provided at bedtime, 16 hours may elapse between a substantial evening meal and breakfast; and

(ii) Not less than 10 hours between breakfast and the evening meal of the same day, except as provided under paragraph (b)(1)(i) of this section.

(2) Food must be served—

(i) In appropriate quantity;  
(ii) At appropriate temperature;  
(iii) In a form consistent with the developmental level of the client; and  
(iv) With appropriate utensils.

(3) Food served to clients individually and uneaten must be discarded.

(c) **Standard: Menus.** (1) Menus must—

(i) Be prepared in advance;  
(ii) Provide a variety of foods at each meal;  
(iii) Be different for the same days of each week and adjusted for seasonal changes; and  
(iv) Include the average portion sizes for menu items.

(2) Menus for food actually served must be kept on file for 30 days.

(d) **Standard: Dining areas and service.**

The facility must—

(1) Serve meals for all clients, including persons with ambulation deficits, in dining areas, unless otherwise specified by the interdisciplinary team or a physician;

(2) Provide table service for all clients who can and will eat at a table, including clients in wheelchairs;

(3) Equip areas with tables, chairs, eating utensils, and dishes designed to

meet the developmental needs of each client;

(4) Supervise and staff dining rooms adequately to direct self-help dining procedure, to assure that each client receives enough food and to assure that each client eats in a manner consistent with his or her developmental level; and

(5) Ensure that each client eats in an upright position, unless otherwise specified by the interdisciplinary team or a physician.

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30-10-205. ICF-MR admission procedure. (a) Admission procedure for ICF's-MR shall be pursuant to 42 CFR 483.440, effective October 3, 1988, which is adopted by reference.

(b) An ICF-MR shall not require a private-paying client to remain in a private-pay status for any period of time after the client becomes eligible for medicaid/medikan.

(c) Each client shall be screened and found eligible for services before the client is admitted in the medicaid/medikan program. The effective date of this regulation shall be January 30, 1991. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective, T-30-10-1-90, Oct. 1, 1990; effective Jan. 30, 1991.)

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well as currently valid assessments of functional developmental, behavioral, social, health and nutritional status to determine if the facility can provide for the client's needs and if the client is likely to benefit from placement in the facility.

(4) If a client is to be either transferred or discharged, the facility must—

(i) Have documentation in the client's record that the client was transferred or discharged for good cause; and

(ii) Provide a reasonable time to prepare the client and his or her parents or guardian for the transfer or discharge (except in emergencies).

(5) At the time of the discharge, the facility must—

(i) Develop a final summary of the client's developmental, behavioral, social, health and nutritional status and, with the consent of the client, parents (if the client is a minor) or legal guardian, provide a copy to authorized persons and agencies; and

(ii) Provide a post-discharge plan of care that will assist the client to adjust to the new living environment.

(c) *Standard: Individual program plan.* (1) Each client must have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to—

(i) Identifying the client's needs, as described by the comprehensive functional assessments required in paragraph (c)(3) of this section; and

(ii) Designing programs that meet the client's needs.

(2) Appropriate facility staff must participate in interdisciplinary team meetings. Participation by other agencies serving the client is encouraged. Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless that participation is unobtainable or inappropriate.

(3) Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. The comprehensive functional assessment must take into consideration the client's age (for ex-

§ 483.440 Condition of participation:  
Active treatment services.

(a) *Standard: Active treatment.* (1) Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward—

(i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and

(ii) The prevention or deceleration of regression or loss of current optimal functional status.

(2) Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

(b) *Standard: Admissions, transfers, and discharge.* (1) Clients who are admitted by the facility must be in need of and receiving active treatment services.

(2) Admission decisions must be based on a preliminary evaluation of the client that is conducted or updated by the facility or by outside sources.

(3) A preliminary evaluation must contain background information as

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ample, child, young adult, elderly person) and the implications for active treatment at each stage, as applicable, and must—

(i) Identify the presenting problems and disabilities and where possible, their causes;

(ii) Identify the client's specific developmental strengths;

(iii) Identify the client's specific developmental and behavioral management needs;

(iv) Identify the client's need for services without regard to the actual availability of the services needed; and

(v) Include physical development and health, nutritional status, sensorimotor development, affective development, speech and language development and auditory functioning, cognitive development, social development, adaptive behaviors or independent living skills necessary for the client to be able to function in the community, and as applicable, vocational skills.

(4) Within 30 days after admission, the interdisciplinary team must prepare for each client an individual program plan that states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section, and the planned sequence for dealing with those objectives. These objectives must—

(i) Be stated separately, in terms of a single behavioral outcome;

(ii) Be assigned projected completion dates;

(iii) Be expressed in behavioral terms that provide measurable indices of performance;

(iv) Be organized to reflect a developmental progression appropriate to the individual; and

(v) Be assigned priorities.

(5) Each written training program designed to implement the objectives in the individual program plan must specify:

(i) The methods to be used;

(ii) The schedule for use of the method;

(iii) The person responsible for the program;

(iv) The type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives;

(v) The inappropriate client behavior(s), if applicable; and

(vi) Provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.

(6) The individual program plan must also:

(i) Describe relevant interventions to support the individual toward independence.

(ii) Identify the location where program strategy information (which must be accessible to any person responsible for implementation) can be found.

(iii) Include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.

(iv) Identify mechanical supports, if needed, to achieve proper body position, balance, or alignment. The plan must specify the reason for each support, the situations in which each is to be applied, and a schedule for the use of each support.

(v) Provide that clients who have multiple disabling conditions spend a major portion of each waking day out of bed and outside the bedroom area, moving about by various methods and devices whenever possible.

(iv) Include opportunities for client choice and self-management.

(7) A copy of each client's individual program plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian.

(d) *Standard: Program implementation.* (1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

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(2) The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.

(3) Except for those facets of the individual program plan that must be implemented only by licensed personnel, each client's individual program plan must be implemented by all staff who work with the client, including professional, paraprofessional and nonprofessional staff.

(e) *Standard: Program documentation.* (1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measureable terms.

(2) The facility must document significant events that are related to the client's individual program plan and assessments and that contribute to an overall understanding of the client's ongoing level and quality of functioning.

(f) *Standard: Program monitoring and change.* (1) The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client—

(i) Has successfully completed an objective or objectives identified in the individual program plan;

(ii) Is regressing or losing skills already gained;

(iii) Is failing to progress toward identified objectives after reasonable efforts have been made; or

(iv) Is being considered for training towards new objectives.

(2) At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed, and the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (e) of this section.

(3) The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior,

and persons with no ownership or controlling interest in the facility to—

(i) Review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights;

(ii) Insure that these programs are conducted only with the written informed consent of the client, parent (if the client is a minor), or legal guardian; and

(iii) Review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, timeout rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other area that the committee believes need to be addressed.

(4) The provisions of paragraph (f)(3) of this section may be modified only if, in the judgment of the State survey agency, Court decrees, State law or regulations provide for equivalent client protection and consultation.

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30-10-206. ICF-MR certification and recertification by physicians. (a) Certification. At the time of admission to an ICF-MR or at the time any ICF-MR client applies for medical assistance under the medicaid/medikan program, a physician or physician extender shall certify that the services must be given on an inpatient basis. Services shall be furnished under a plan established by the physician or physician extender before authorization of payment. Before reimbursement is approved, a screening team designated by the secretary shall review the physician's or physician extender's certification and shall certify that services in an ICF-MR are the most appropriate services available for the individual. The certification of need shall become part of the individual's medical record. The date of certification shall be the date the case is approved for payment and the certification is signed.

(b) Recertification.

(1) Each ICF-MR shall be responsible for obtaining a physician's or physician extender's recertification for each client.

(2) The recertification shall be included in the client's medical record. Recertification statements may be entered on or included with forms, notes, or other records a physician or physician extender normally signs in caring for a client. The statement shall be authenticated by the actual date and signature of the physician or physician extender.



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(c) If the appropriate professional refuses to certify or recertify because, in the professional's opinion, the client does not require ICF-MR care on a continuing basis, the services shall not be covered. The reason for the refusal to certify or recertify shall be documented in the client's records. The effective date of this regulation shall be January 30, 1991. (Authorized by and implementing K.S.A. 39-708c, as amended by L. 1990, Chapter 152; effective, T-30-10-1-90, Oct. 1, 1990; effective Jan. 30, 1991.)

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30-10-207. ICF-MR inspection of care and utilization review. (a) The inspection of care team from the Kansas department of health and environment shall conduct an inspection of care and utilization review of each medicaid/medikan client in all intermediate care facilities for the mentally retarded certified to participate in the medicaid/medikan program.

(b) Each ICF-MR shall cooperate with authorized representatives of the agency and the department of health and human services in the discharge of their duties regarding all aspects of the inspection of care and utilization review.

(c) Any ICF-MR where the utilization review team finds inappropriately placed clients shall be responsible for providing transportation for the clients to a more appropriate placement facility. The effective date of this regulation shall be October 1, 1991. (Authorized by and implementing K.S.A. 1990 Supp. 39-708c; effective, T-30-10-1-90, Oct. 1, 1990; effective Jan. 30, 1991; amended Oct. 1, 1991.)